Senate Joint Resolution 799

Interim Report to the Tennessee General Assembly

April 1, 2007

Overview of SJR799 Study

Background:

This is the first of two reports required by Senate Joint Resolution 799 which was passed by the Tennessee State Legislature during the last term of the 104th General Assembly in 2006. The Select Committee on Children and Youth is directed by SJR799 to study the mental health needs of Tennessee's children [Attachment 1: SJR799]. This interim report includes the following three (3) parts:

1. A blueprint, or outline, of a statewide system for delivering publicly funded mental health services to children that will intentionally improve the outcomes realized by those children, their families, and all stakeholder groups, including education, child welfare, juvenile justice, and all facets of health care.
2. A work plan to guide the activities of the second year of the SJR799 study process that will center on defining and detailing critical legislative components of a comprehensive and coordinated system of care.
3. Documentation and description of the mental health needs of children and the gaps and barriers that exists that prevent those needs from being met..

SJR799 calls for a final report with recommendations to be completed and submitted to the General Assembly on or before April 1, 2008. The Select Committee intends to continue

working diligently to complete the intent and stated directives of this important and timely resolution.

Synopsis of First Year Study Activities**:**

A subcommittee of the Select Committee was appointed and has led the SJR799 study process. The members of this subcommittee are:

Representative Sherry Jones, Chair

Senator Diane Black	Representative John DeBerry
Senator Charlotte Burks	Representative Beth Harwell
Senator Thelma Harper	Representative Richard Montgomery
Senator Raymond Finney*	Representative Harry Brooks*

The overarching goals of the subcommittee in producing this interim report have been to engage and utilize assistance of core partners, secure expert advisement, and obtain consumer and provider input. The Department of Mental Health and Developmental Disabilities (DMHDD), the Tennessee Commission on Children and Youth (TCCY) and Tennessee Voices for Children (TVC) have been involved as core partners. With the support of these partners, the subcommittee has achieved these goals by executing three (3) specific strategies for gathering information and receiving input on the issues:

1. Strategy 1 – Subcommittee Hearings: to date, three (3) hearings have been conducted through which expert and consumer testimony and advisement has been received.

(*Legislators newly appointed in February as members of the Select Committee on Children and Youth who will be serving on the subcommittee.)

2. Strategy 2 – Conduct town hall meetings in various communities around the state: to date, three (3) such meetings have taken place; Nashville in October 2006 in conjunction with the Tennessee Voices for Children's statewide conference, Jackson in January 2007, and Cookeville in March 2007. Additional town hall meetings will be held in the coming months.
3. Strategy 3 – Administration of a survey document among broad, diverse stakeholder groups that have included attendees of town hall meetings as well as consumers, advocates, and professionals associated with education, juvenile justice, mental health, and child welfare. [Attachment 2: SJR799 Children's Mental Health Survey]

PART 1

What should a service delivery system for children's mental health problems look like?

The enormity and scope of the children's mental health problems are great, yet good mental health is essential to their total health, well being, and future as economically productive, law-abiding citizens of Tennessee. This should be the vision for children's mental health reform in this state. The goal to accomplish this mental health care reform should be to design, implement, and fully support an integrated system of care. The system of care should assure children's needs are: (1) timely recognized and acknowledged; (2) accurately identified and diagnosed; (3) appropriately addressed and treated so as either to ameliorate the condition completely or to stabilize the symptoms and minimize the debilitating effects of the condition in the child's growth, development and daily functioning; and (4) inclusive of parents/caregivers and their children as full partners in planning and carrying out their treatment and care.

The directives of SJR799 for legislative consideration of children's mental health reform are in keeping with similar efforts around the country. Currently, about 2/3 of the states have laws in place that create a policy framework of comprehensive and coordinated systems of children's mental health care. Experts in the field of children's mental health who have observed, guided and evaluated this type of state-level system reform indicate several reasons this type of legislation is important. First, it codifies the system of care in law and thus creates the mandate authority for public agencies in children's mental health care to act in certain ways. Just as importantly, system of care law should establish both expectations and

limitations for the actions of those agencies and publicly funded service providers. Well designed and enacted system of care laws should reflect a genuine balance between the public good and the public's fiscal resources.

While every state's system of care legislation differs somewhat, there are typical features and key components common to all. Legislation articulates a vision for the care of children and families along with a set of values and principles that set forth the framework for the state-level mental health policy framework. Another core legislative component is the identification of the population on which the system will focus. The services and supports the system provides are identified and defined in legislation, as are the participants both expected and mandated to be involved to carry out the system's processes. Legislation clearly and meaningfully espouses parents and families as highly valued and central to decision-making about their children's care, and the roles of all participants/agencies are clearly articulated in legislation. Finally, system of care legislation typically establishes clear expectations and a framework for interagency cooperation and coordination of efforts, including authority and duty to establish non-categorical funding streams and processes. Numerous demonstration projects funded and evaluated by the federal agency, Substance Abuse and Mental Health Services Administration (SAMHSA), over the past two (2) decades demonstrates that the system of care policy framework is effective and successful in improving outcomes for children with mental health problems. The basic system of care values and principles are sound and appropriate for development of effective public policy

Set forth in resolving clauses of SJR799 are expectations that an improvement in the mental health care system for Tennessee's children should include core system of care features and

characteristics. Our improved system should include a comprehensive array of appropriate services and supports. The processes of identifying needs, and then utilizing the services and supports in the course of treatment should be streamlined and coordinated among all care participants. Our children's parents and caregivers must be included as full partners in the treatment and care of their children, the system must be family-centered. Our mental health services and practice must be culturally responsive so as to optimally address the needs of the ethnically, socio-economically, and geographically diverse populations of children and families living all across the state.

There are specific system of care projects presently being implemented in Tennessee. DMHDD in partnership with TVC, Centerstone and Vanderbilt Institute of Public Policy Studies used SAMHSA grant money for some seven (7) years to demonstrate the system of care in Nashville, and the evaluation results are readily available and positive. Currently, the department is partnering with Maury County, TVC and Centerstone in implementing the "Mule Town System of Care Project". Memphis/Shelby County Juvenile Court is building a system of care for youth in the juvenile justice system called, JustCare for Kids. There is a system of care in Knox County for supporting children with mental health needs who are transitioning because of age, to the adult mental health system .

System of care is by no means a new concept in Tennessee, but it is not universal across the state. More importantly, the concept, policy framework and guidelines do not permeate the work and practice of all the child-serving departments and agencies. But children who have mental health needs do show up in every arena, every community, every school, every juvenile court across the state. The opportunity of SJR799 is to design and create an

implementation plan that will provide a system of care approach for children with mental health needs and their families in their natural environments. It is completely reasonable for policymakers and all stakeholders to expect that with implementation of a well designed , implemented and managed system of care that the outcomes for children with mental heath needs will be improved, and the accountability for the public dollars used to serve them will be much improved, as well.

PART 2

What needs to be done in Year 2 of the SJR799 process that will lead Tennessee to a well-designed, implementable and successful system of care to address children's mental health needs?

It should be considered conclusive from the collective body of information that has come together through activities of Year 1 of the SJR799 study process that there is serious interest and momentum around children's mental health reform. Many inquiries from diverse parties have been made to Select Committee members and staff, and a ready willingness to be involved in the process has come forth from numerous stakeholder groups. Across all groups there has been a collective expression of seeing the directives of SJR799 as creating an important opportunity to improve the policy and practice around children's mental health.

During the second year of the study process, information gathering efforts should continue, with emphasis being placed on hearing the consumer voice of parents, families and youth. Surrogate caregivers such as foster parents, grandparents and other relatives who are raising children are important stakeholder groups that should also be targeted for input.

The three (3) strategies that have guided the subcommittee's work during the first year of study – legislative hearings, town hall meetings, and administering the SJR799 Survey – should continue to be implemented. Some specific recommendations on each strategy are:

- Legislative hearings should be held at the call of the chair to hear testimony on specific topics identified by subcommittee members as relevant to continued study and development of recommendations for the final SJR799 report due April 1, 2008.

- At least two (2) town hall meetings should be held in each of the state's grand divisions; additionally, at least (1) meeting should be held in each of the four (4) major metropolitan areas. A recommended timeline for completing the series of town hall meetings would be by mid-September.
- The survey should continue to be used for collecting information from a broad base of stakeholders and administered at all town hall meetings. Additional groups who are willing to be surveyed should be identified especially tapping into readily accessible settings such as training meetings and conferences, newsletters, and websites.

Also, in keeping with the recommendation that the subcommittee heard in the expert testimony of Cliff Davis at the November 16, 2006 hearing, it is highly advisable that a broad-based task force of stakeholders should examine, analyze and make recommendations for the design of specific components of a statewide system of care. The task force should work to detail design of the following such component parts: data collection/information management; inventory of existing services/determine what adequate array of services would be; workforce development/professional credentialing/streamlining regulatory matters; identify system participants/define roles and responsibilities; interagency framework of practice; needs-driven resource allocation; and accountability/achieve desired outcomes. The subcommittee should monitor the task force's activities; they may take the task force's work products under advisement and give consideration to its recommendations in the development of the SJR799 final report.

The subcommittee should continue utilizing expert consultation and technical assistance such as Mr. Davis has provided, especially for the purposes of examining model system of care

legislation from other states. Some level of this type of assistance may be available in Year 2 through state departments and agencies that have established access to expert consultation. However, it would be advisable that a funding source being identified and made available to the Select Committee to cover such professional services if the need arises.

PART 3

What kinds of mental health problems do Tennessee children have and how serious are their problems?

As in any productive public policy discussion and debate, the semantics along with commonly understood and accepted definitions of key terms is vitally important. This is certainly true and relevant discussing and studying children's mental health issues.

A myriad of conditions exist that, when manifest among people of any age, result in what is commonly referred to as "mental health problems," and for which provision of "mental health services" is deemed necessary and appropriate. The data and information reported herein exemplifies what this multiplicity of conditions and problems looks like among the population of Tennessee's children, which numbers approximately 1.4 million. Systemic barriers exist in multiple areas and are described herein that contribute to fragmented service delivery processes at junctures all along the way from initial identification of needs through treatment activities.

Prevalence and Nature of Mental Health Problems:

Diagnosable Mental/Emotional Disorder. . .

- Approximately 68,000 in Tennessee children meet the diagnostic criteria of being seriously emotionally disturbed; approximately 45,500 of these children are enrolled in TennCare. (2004 CPORT/TCCY)
- 1 in every 5 children has a diagnosable mental disorder; however, only 1 in every 3 receives treatment. (Tennessee Voices for Children presentation to Select Committee)

- Half (50%) of all children in state custody, including 69% of the adolescents and 84% of all adjudicated delinquents, have a mental health diagnosis. (2004CPORT/TCCY)
- During school year 2003-04, there was a total of 171,390 special education students in Tennessee; 5,232 of those students were eligible because of a diagnosed emotional disturbance; however, a large proportion of the rest of the special education population would also have been in need of or receiving mental health services. **For the school year ending in 2004-05, 175,692 students were enrolled in special education; in school year 2005-06, the number of children reported as eligible for special education was 151,556. (Tennessee Department of Education website)
- A 1996 study by Lavigne et al. in looking at a large pediatric sample of more than 3,800 preschool-age children found 21% met the criteria for a psychiatric disorder, 9% of them for a severe disorder. (Early Childhood Research & Practice, 1996)

Depression and Suicide. . .

- According to the 2005 Youth Behavior Risk Survey, 28.3% of all Tennessee student respondents felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months; 17.5% of the total Tennessee student respondents seriously considered attempting suicide during the past 12 months.
- In 2004, suicide was the reported cause of death of 45 Tennessee children between the ages of 10-19; in 1/3 of Tennessee's counties the suicide rate for this age cohort exceeds the national rate. (Tennessee Suicide Prevention Network website)
- In February 2007, the federal Centers for Disease Control and Prevention reported that from 2003 to 2004 the number of suicide deaths of children under 19 years of age

rose from 1,737 to 1,985 – an increase of 18.2% which was largely driven by older teen deaths.

ADHD…

- 4.79% of youth 4-17 have ever been diagnosed and currently medicated for Attention-Deficit/Hyperactivity Disorder. (National Survey of Children's Health, 2003)
- A study published in the August Archives of Pediatrics & Adolescent Medicine found that nearly one in 100 adolescent TennCare recipients had been prescribed an antipsychotic medication.

Alcohol and Drug Use…

- In 2003, an estimated 21,000 children ages 12–17 in Tennessee needed but had not received treatment for illicit drug use in the past year. (CWLA Tennessee's Children 2006)
- In 2003, an estimated 22,000 children ages 12–17 needed but had not received treatment for alcohol use in the past year**.** (CWLA Tennessee's Children 2006)
- 74.0% of Tennessee students have had at least one drink of alcohol on one or more days during their life (Youth Behavior Risk Survey, 2005)
- 43.4 % of Tennessee students say they have used marijuana one or more times during their life. (Youth Behavior Risk Survey, 2005)
- Of the all the adolescent children in state custody, 48% have substance abuse issues; of the delinquent population in state custody, 72% of them have substance abuse issues. (2004 CPORT/TCCY)

Impact on Learning. . .

- A RAND Corporation publication, *Investing in Our Children*: *What We Know and Don't Know About the Costs and Benefits of Early Childhood Interventions*, supports the proposition that carefully targeted early childhood interventions can yield measurable benefits, such as gains in emotional or cognitive development for the child, typically in the short run, or improved parent-child relationships; and improvements in health-related indicators, such as child abuse, maternal reproductive health, and maternal substance abuse.
- Research shows that Head Start and similar pre-kindergarten programs cut crime; children left out of Head Start are more likely to commit crimes when they grow up compared to children who did attend the program. (www.fightcrime.org)
- Early childhood intervention programs also can contribute in important ways to the mental health of children by enhancing the social and emotional development of the child (Niles, Reynolds, Ou, & Lee, 2003; Niles, 2004; Reynolds, 2000; Schultz, 2000). (Early Childhood Research & Practice)
- The limited research on early childhood programs takes on additional importance because it has been suggested that 10% to 13% of preschoolers (ages 1 to 6 years old) have diagnosable emotional or behavioral disorders (Institute of Medicine, 2001).
- In a May 2005 study that reported state rankings on expulsion rates of children from preschools, Tennessee had the 8th highest expulsion rate in the nation at 3.79 per 1000. The primary reason for expulsion from a preschool is problematic behavior by the child that cannot be safely managed by the preschool staff. (Source: The

Foundation for Child Development findings as reported by the Southern Early Childhood Association)

Co-Occurring Disorders…

- SAMHSA's 1998 statistics sourcebook estimated 20 million people have some type of substance use disorder in a given year, 8 million of whom will also have a co-occurring mental health disorder. This comprises 4.7% of the age 15-54 population of the U.S. Of those with a substance use disorder during a given year, 42 percent also have a mental health diagnosis (52 percent lifetime).
- According to the National Comorbidity Study (1991), 56% of all persons aged 15-54 years with a mental or addictive disorder have at least one other co-occurring disorder. (Kissler, 1994)
- Adolescents with serious emotional problems are nearly four times more likely to be dependent on alcohol and/or drugs than adolescents with low levels of emotional problems. (U.S. DHHS, 1999; SAMHSA)
- Co-Occurring Disorders affect from 7 to 10 million adults in the U.S. each year (Ibid)
- Children, youth, and older adults also may experience co-occurring substance abuse disorders and mental disorders. For youth, forty-three percent (43%) of those receiving mental health services in the United States have been diagnosed with a COD (CMHS, 2001)
- A "1 Day Census" survey of all juveniles held in 40 secure state Tennessee facilities documented: (Criminal Justice/Mental Health Committee, TDMHDD Planning Council, June 2004)

1. 53% of the youth in juvenile justice facilities were experiencing mental health problems.
2. 15% were taking some type of psychiatric medicine while in the juvenile justice facilities.
3. 42% were known to have substance abuse problems.
4. 30% had co-occurring mental health and substance use problems.

- The chief administrative officer of Memphis/Shelby County Juvenile Court has stated that access to mental health services is the single largest barrier the court faces to being able to effectively divert children from the juvenile justice system. On 3.9.07, 234 juveniles detained securely by that court, 26% had 10 or more prior complaints; 74% had 5 or more prior complaints, and only 4% had just 1 prior complaint (Shelby County Juvenile Court data)

Some of these mental health problems noted throughout the prevalence data and information are, in fact, biologically-based illness; others of these conditions are the result of environmental factors and behavioral responses. However, research funding suggests that regardless of the etiology of the specific illness or disorder, when these conditions go untreated, the results are a diminution of the affected individual's state of mental wellness and their ability to function satisfactorily within their homes, families, schools and communities.

<u>Barriers related to Provider Availability and Professional Practice</u>:

Significant issues have emerged around availability of appropriately trained professionals who can best identify and treat children with mental health problems. May 2006 information

from the Tennessee Board of Examiners lists 1,244 psychologists and 634 psychological examiners licensed to practice in the state, however, the percentage of these professionals who have child-specific special training and/or include children in their practice is not known. And, while the use psychotropic medications has increased in children, there are less than 100 child/adolescent psychiatrists practicing in the state, and the state's pediatric community by and large is not properly trained to diagnosis and manage treatment of serious mental illness. This is of particular concern as there continues to be high level dialogue and debate in the medical and pharmaceutical communities about the safety and efficacy of drugs being used to treat psychosis, depression, anxiety, mood disorders, and attentional problems in children.

Concerns surrounding timely and accurate screening, assessment, and diagnostic evaluations for children are extensive; however, the nature of the concerns vary significantly among and within the various stakeholder groups. In general, parents express a desire for educators to be better trained, willing and able to more effectively work with children exhibiting anxiety, frustration or anger. Likewise and in general, classroom-level educators want to do just that, but indicate they are much in need of assistance in: (1) managing the symptomatic behavior, especially when it reaches disruptive, crisis level; (2) mental health-related consultation and assistance developing and implementing child-specific instruction and behavior management plans; and (3) knowledge to share with parents about appropriate community-based programs and services to which children can be referred for mental health services.

Barriers of Pronounced Significance in Special Populations:

Among two (2) special populations of children, those involved in the child welfare and in the juvenile justice systems, the inadequacies of the current mental health care resources and delivery system speak for themselves by the known incidences as well as co-occurrence of mental illnesses, behavioral problems, and substance abuse. Biological-based mental illness notwithstanding, children who experience maltreatment in the forms of physical or sexual abuse, by emotional abandonment and attachment failure, through secondary effects of domestic violence, or from the effects of their parents' unmet mental health needs or addictions are almost certain to have mental health needs and require therapeutic services.

Barriers Related to Sufficiency of Resources:

A pervasive sense exists that there is a lack of services and supports available to address the mental health needs of children, and this situation is the result of not enough state funding being allocated and directed for these purposes. Informants to this process have clearly indicated they know and/or believe care at all levels -- community-based, acute/in-patient for crisis stabilization and forensic evaluation, and longer-term residential, especially for addictions treatment -- is lacking in terms of availability, accessibility, and qualitative effectiveness. There is also the sense that improved community mental health supports and services would reduce the need for more restrictive services.

Barriers Related to Regulatory Controls on Access:

The regulatory barriers impacting the delivery of mental health care are not unique to public funding payor sources. Even when third-party payor sources are available to consumers through private insurance, parents face significant barriers accessing appropriate services in a

timely manner. The provider shortages noted previously affect all consumers equally in terms of being able to get services when they are needed. Caps on mental health care benefits create barriers to maintaining therapeutic interventions of sufficient intensity and duration to achieve the treatment outcomes desired. Lack of parity between medical benefits and mental health benefits in private coverage plans has been noted. Once private mental health insurance benefits are exhausted, families must then turn to public funding sources; however, income guidelines and means testing as conditions of qualifications may preclude their eligibility for TennCare or any of the other state-funded health care plans.

Mental health funding resources are spread out among several state agencies and the respective programs therein. Medicaid dollars administered through the TennCare program and managed by the behavioral health organization (BHO) are the primary source of mental health care funds for children served by Families First/TANF program and some other groups of children who are determined income eligible. Likewise, TennCare dollars are primary funds for services for DCS children – both child welfare and juvenile justice, with the exception of delinquents in secure detention settings. There are concerns about availability and access with respect to TennCare-funded services across all populations, and they center around an inadequate number of providers in the BHO network. The uneven geographic distribution of network providers creates underserved areas and exacerbates the impact of the number one access-related problem which is transportation.

Education dollars that support mental health services move through several funding channels that vary in regulatory requirements. Some portion of the Basic Education Plan (BEP) formula, special education, federal Drug Free Schools, Coordinated School Health Programs (CSHPs), and special pilot projects such as Safe Schools, Healthy Students are used for

mental health services. But the nature of mental health services in the education arena is not necessarily synonymous with the typically understood therapeutic purpose and intent of mental health services. The BEP funds do provide for school counselors, however, the actual student:counselor ratio varies among school districts; also, the actual duties counselors carry out varies especially between the elementary, middle and high school grades. Use of special education dollars is tightly regulated by federal law, and when spent for therapeutic mental health services the recipient child is most often seriously mentally ill and usually in a highly restrictive setting. Use of dollars that flow through the other named education funding sources are regulated by the terms of the respective funding source such that therapeutic mental health care is not a targeted purpose.

Program licensing and professional credentialing regulations applicable to mental health clinicians, counselors, and substance abuse treatment providers have been noted to need better coordination. Among Department of Children's Services, the Bureau of Alcohol and Substance Abuse, and both TennCare/BHO and private insurers, different licensing and credentialing requirements create procedural confusion and/or conflict, cause duplication of effort, and at times negate the ability of third-party payor sources, both TennCare and private insurers, to cover the cost of care. There is some belief that opportunities do exist to better align requirements and streamline procedures among these agencies' current practice that, if acted upon, would eliminate at least some regulatory barriers that now exist.

Conclusion

The SJR799 study process to date has yielded a reasonably good conceptual grasp of how effective systems of care should be constructed in policy and carried out in practice. At this juncture, the mental health needs of Tennessee's children are reasonably well known and documented. It can credibly be stated that there is a need to reform and improve our children's mental health system – consumers, providers and state agencies are in general agreement that a truly coordinated, more comprehensive care system is needed. The opportunity is before policymakers to charge and empower a task force of stakeholders – especially including parents and families – to work through Year 2 of the SJR799 study process and bring forth recommendations for legislation that will create Tennessee's own unique model system for children's mental health care.

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